GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ANTICONVULSANTS PA SUMMARY

Preferred	Non-Preferred
Carbamazepine IR, SR and ER generic Celontin (methsuximide) Depakote Sprinkles (divalproex sprinkles) Diastat (diazepam rectal gel)* Divalproex DR and ER generic Gabapentin capsules and solution generic Lamotrigine tablets and chewable dispersible tablets generic Levetiracetam tablets and oral solution generic Lyrica capsules (pregabalin) Oxcarbazepine generic Oxtellar XR (oxcarbazepine SR)* Peganone (ethotoin)Phenytoin generic Primidone generic Qudexy XR (topiramate ER)* Topiramate IR sprinkle capsules, tablets generic Topiramate ER generic* Valproic Acid syrup generic Vimpat oral solution, tablets (lacosamide) Vimpat injectable (lacosamide)* Zonisamide generic	Aptiom (eslicarbazepine) Banzel suspension and tablets (rufinamide) Briviact (brivaracetam) Diazepam rectal gel generic Divalproex sprinkles generic Felbamate generic Fycompa oral suspension and tablets (perampanel) Gabapentin tablets generic Gabitril (tiagabine) Lamictal Kits (lamotrigine IR, ODT and XR kits) Lamictal ODT (lamotrigine) Lamotrigine kits generic Lamotrigine ER and ODT generic Levetiracetam ER tablets generic Lyrica CR (pregabalin extended-release) Lyrica oral solution (pregabalin) Onfi oral suspension and tablets (clobazam) Sabril tablets and powder for solution (vigabatrin) Stavzor (valproic acid delayed release capsules) Tiagabine generic Trokendi XR (topiramate SR) Valproic Acid capsules generic

*Preferred agents that require prior authorization.

LENGTH OF AUTHORIZATION: Varies

NOTES:

- Criteria for Horizant and Gralise are listed in the Gabapentin Products PA Summary.
- Brand Diastat requires PA for members 21 years of age and older; generic diazepam rectal gel requires PA for members of all ages.
- If generic diazepam rectal gel is approved, the PA will be issued for brand Diastat rectal gel. If generic tiagabine is approved, the PA will be issued for brand Gabitril. If generic lamotrigine ODT is approved, the PA will be issued for brand Lamictal ODT. If generic lamotrigine kits are approved, the PA will be issued for brand Lamictal Kits.

PA CRITERIA:

Aptiom

- ❖ Approvable for members 4 years and older with a seizure disorder (epilepsy) who have tried and failed at least two preferred anticonvulsants, one of which must be oxcarbazepine.

Banzel

- Approvable for members 1 year of age and older with seizures associated with Lennox-Gastaut Syndrome (LGS) who have had an insufficient response to at least two anticonvulsants used for LGS and when used in combination with another anticonvulsant for LGS.
- In addition for the suspension, member must be unable to swallow solid dosage forms or must require a dose that cannot be delivered by administering the tablets.

Briviact

- Approvable for members 4 years and older with a seizure disorder (epilepsy) who have tried and failed at least two preferred anticonvulsants, one of which must be levetiracetam.
- In addition for the injection, approvable for members who have received clinical benefit from Briviact tablets or oral solution and have temporary inability to swallow, tolerate or absorb the tablets or oral solution. Briviact injection must be administered in member's home by home health or in a long-term care facility.

Diastat and Diazepam Rectal Gel Generic

- Approvable for members with a seizure disorder (epilepsy) who are currently on a stable antiepileptic drug regimen and are experiencing increased bouts (clusters) of seizure activity different from the member's ordinary seizure activity.

Divalproex Sprinkles Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Depakote Sprinkles, is not appropriate for the member.

Felbamate Generic

- Approvable for members 2 years of age and older with a seizure disorder (epilepsy) who have tried and failed at least two preferred anticonvulsants.
- Member, parent or guardian must provide signed acknowledgement that they are aware of the risks associated with therapy.

Fycompa

- Approvable for members 12 years of age and older with a seizure disorder (epilepsy) who have tried and failed at least two preferred anticonvulsants.
- In addition for Fycompa oral suspension, member must be unable to swallow solid dosage forms or require a dose that cannot be delivered by administering the tablets.

Gabapentin Tablets Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, gabapentin capsules, is not appropriate for the member.

Gabitril and Tiagabine Generic

- Approvable for members 12 years of age and older with a seizure disorder (epilepsy) who have tried and failed at least two preferred anticonvulsants and when used in combination with another anticonvulsant.

Lamictal ODT and Lamotrigine ODT Generic

- Approvable for members with bipolar disorder who are unable to swallow solid dosage forms.
- Approvable for members with a seizure disorder (epilepsy) who are unable to swallow solid dosage forms and who have tried and failed at least two preferred anticonvulsants

OR

- For members that are able to swallow solid dosage forms, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, lamotrigine tablets or chewable dispersible tablets, is not appropriate for the member.

Lamotrigine ER Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, lamotrigine tablets or chewable dispersible tablets, is not appropriate for the member.

Lamictal Kits and Lamotrigine Kits Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the non-kit formulation is not appropriate for the member.

Levetiracetam ER Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic immediate-release levetiracetam tablets or solution, is not appropriate for the member.

Lyrica CR

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Lyrica immediate-release, is not appropriate for the member.

Lyrica Oral Solution

- Approvable for members less than 18 years of age with neuropathic pain due to chemotherapy.
- Approvable for members who are unable to swallow capsules.

Onfi

- Approvable for members 2 years of age and older with seizures associated with Lennox-Gastaut Syndrome (LGS) who have had an insufficient response to at least two anticonvulsants used for LGS and when used in combination with another anticonvulsant for LGS.
- In addition for the oral suspension, member must be unable to swallow solid dosage forms or must require a dose that cannot be delivered by administering the tablets.

Oxtellar XR

- Approvable for members with claims history trial of an oxcarbazepine immediate-release product
  OR
- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic oxcarbazepine immediate-release tablets, is not appropriate for the member.

Qudexy XR and Topiramate ER generic

- Approvable for members with claims history trial of a topiramate immediate-release product

OR

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, topiramate immediate-release generic, is not appropriate for the member.

Sabril

- Approvable for members 1 month to 2 years of age with infantile spasms.
- Approvable for members 10 years of age and older with refractory complex partial seizures who have tried and failed at least three other anticonvulsants and when used in combination with another anticonvulsant.
- Prescriber and member must be enrolled in the Sabril SHARE program.
- Prescriber and member must be aware of the risks of permanent vision loss/reduced visual acuity and the need for visual monitoring during therapy and for up to 6 months after therapy discontinuation.
- Member must see an ophthalmologist for a baseline visual assessment.

Stavzor and Valproic Acid Capsules Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, divalproex DR, Depakote sprinkles, divalproex ER, or valproic acid syrup, are not appropriate for the member.

Trokendi XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, generic topiramate immediate-release, Qudexy XR and generic topiramate extended-release, are not appropriate for the member.

Vimpat Injection

- ❖ Approvable for members 17 years of age or older with a seizure disorder (epilepsy) who have received clinical benefit from Vimpat tablets and have temporary inability to swallow, tolerate or absorb the tablets or oral solution. Vimpat injection must be administered in member's home by home health or in a long-term care facility.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **Optum Rx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.